for approval before the end of that State fiscal year or that 90-day period.

(b) *Amendments relating to eligibility or benefits.* A State plan amendment that eliminates or restricts eligibility or benefits may not be in effect for longer than a 60-day period, unless the amendment is submitted to CMS before the end of that 60-day period. The amendment may not take effect unless—

(1) The State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law; and

(2) The public notice was published before the requested effective date of the change.

(c) *Amendments relating to cost sharing.* A State plan amendment that implements cost-sharing charges, increases existing cost-sharing charges, or increases the cumulative cost-sharing maximum as set forth at § 457.560 is considered an amendment that restricts benefits and must meet the requirements in paragraph (b) of this section.

(d) *Amendments relating to enrollment procedures.* A State plan amendment that implements a required period of uninsurance, increases the length of existing required periods of uninsurance, or institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

(e) *Amendments relating to the source of State funding.* A State plan amendment that changes the source of the State share of funding can take effect no earlier than the date of submission of the amendment.

(f) *Continued approval.* An approved State plan continues in effect unless—

(1) The State adopts a new plan by obtaining approval under § 457.60 of an amendment to the State plan;

(2) Withdraws its plan in accordance with § 457.170(b); or

(3) The Secretary finds substantial noncompliance of the plan with the requirements of the statute or regulations.

§ 457.70 Program options.

(a) *Health benefits coverage options.* A State may elect to obtain health benefits coverage under its plan through—

(1) A separate child health program;

(2) A Medicaid expansion program; or

(3) A combination program.

(b) *State plan requirement.* A State must include in the State plan or plan amendment a description of the State's chosen program option.

(c) *Medicaid expansion program requirements.* A State plan under title XXI for a State that elects to obtain health benefits coverage through its Medicaid plan must—

(1) Meet the requirements of—

(i) Subpart A;

(ii) Subpart B (to the extent that the State claims administrative costs under title XXI);

(iii) Subpart F (with respect to determination of the allotment for purposes of the enhanced matching rate, determination of the enhanced matching rate, and payment of any claims for administrative costs under title XXI only);

(iv) Subpart G; and

(v) Subpart J (if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims based on a community based health delivery system).

(2) Be consistent with the State's Medicaid State plan, or an approvable amendment to that plan, as required under title XIX.

(d) *Separate child health program requirements.* A State that elects to obtain health benefits coverage under its plan through a separate child health program must meet all the requirements of part 457.

(e) *Combination program requirements.* A State that elects to obtain health benefits coverage through both a separate child health program and a Medicaid expansion program must meet the requirements of paragraphs (c) and (d) of this section.

§ 457.80 Current State child health insurance coverage and coordination.

A State plan must include a description of—

(a) The extent to which, and manner in which, children in the State, including targeted low-income children and